The Alchemy of Connection

A Fundamental Ingredient When Supporting Breastfeeding Dyads

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Background*: Every encounter in lactation care should aim to set the ground for an emerging human connection between the lactation consultant (LC) and the breastfeeding mother. Cultivating connection is as important as adequate clinical competencies and effective communication skills.*

Methods: *The article proposes a hermeneutics of care that articulates elements that enhance the understanding between the LC and the circumstances and realities of the breastfeeding dyad in the context of diagnosis, management, and healing. These elements can be best described by Martin Buber's (2013) I–Thou approach, which we use to enter into a relationship.*

Results: *When the LC has the courage and humility to convey her full presence for that mother and her circumstances, connection has been primed. The quality and depth of the LC– breastfeeding mother relationship, in turn, enhances diagnosis and healing options, particularly in chronic cases.*

Conclusions: *The "alchemy of connection" opens the ground for a relation of mutual trust between the LC and the mother and her world, which supports better breastfeeding care.*

Keywords: lactation care; lactation consultant; patient/client relation; human connection

For effective diagnosis, treatment, and healing to occur, a close understanding is needed by the lactation consultant (LC) of the breastfeeding mother (patient/-client). This article examines the dimensions of human connection between the LC and the mother using the hermeneutics of care as a method. Hermeneutics comes from the word *hermeneia* (Aristotle, 1941), which in ancient Greek meant interpretation, and is defined as the theory and methodology of interpretation (Coreth, 1972; Gadamer, 1984; Palmer, 1969). Modern hermeneutics includes both verbal and nonverbal communication.

Background

Cultivating human connection in lactation care is as important as having adequate clinical competencies and polished communication and counseling skills. But it is particularly relevant when the breastfeeding dyad does not get a resolution of symptoms. The role of noninstrumental, interpersonal connection in breastfeeding and lactation care values the relation with the mother, helping to relieve stress as the mother knows she is not alone and can turn to someone at any moment.

Nevertheless, as Sandel (2012) implied, connection, while valuable in itself, can be hindered if pursued instrumentally. A noninstrumental approach to a relation sees value in the relation itself, and not solely in that relation's expected payoffs (Bruni, 2008, 2012). The LC can choose to see only the instrumental aspect of the relation by focusing on the causes, symptoms, and management of the breastfeeding problem while ignoring the role of the LC relation with the mother, or they can choose to enter into a relationship of care with the mother to interpret her condition, and from there examine how best to offer support.

Central to the proposition is what Dr. Mimi Guarneri from the Academy of Integrative Health and Medicine stated: "It is the quality of the relationship that is the key contributor to the healing process" (Guarneri, 2014, p. 6). In lactation care, clinical skills and clinical judgment (an instrumental rationale) are used to tackle the

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problem(s); communication and counseling skills are used to establish a rapport (an epistemological rationale, i.e., what we know about our relation). The logic of connection (a hermeneutical rationale, i.e., what we understand from the relation) can illuminate crucial dimensions of the LC-breastfeeding mother relation and its role in healing.

Research Findings

The physiology of connection or "interpersonal neurobiology" underlies the different systems people have to connect with one another. "Human connection creates neuronal connections" (Siegel, 2015, p. 85). Studies in neuroscience and medicine support this view: as the right and left brain are integrated, new neural networks are created and the interwoven process of connection unfolds: we are wired to connect (Fishbane, 2007).

Mothers are no exception: they seek human connection with the LC for its own sake, and not only as part of a service sought. Watson's (2008) theory of care highlighted similar aspects (Clark, 2016), while Naef (2006) stressed the role of this relation within the therapeutic process, as did Monbiot (2017), when assessing the benefits of connection stressed the damaging effects of isolation.

The personal components of a noninstrumental approach to a relation can be best described by Buber's (2013) approach. Buber mentioned that there are two fundamental ways of disclosing a relation: the way of the *I–It*, which we as individuals use to manipulate things instrumentally, without ever involving the whole person; and the way of the *I–Thou*, which we as persons use to enter into a relation with other persons; when we pronounce "thou," we do so with the lived experiences of the whole person, this being the result of a grace—a mutual choice, which entails a willingness and an involvement. In this vein, Arman (2007) described, when referring to care, that a relation or connection requires courage, presence, and genuineness, which makes us vulnerable (Brown, 2012; Bruni, 2012).

These qualities are necessary for the LC to bear witness to the mother's problem, which can involve a transformation that is crucial to the healing process. As Lévinas (1985) argued in "Ethics and Infinity," we have a moral responsibility to "be with" our client/patient, fostering and maintaining a human connection and not just addressing causes and symptoms.

The world of the *I–Thou* has three invisible connectors, which, as in any hermeneutic process, relate in a circular manner: the bridge, the relational space, and the encounter (see Table 1).

As Friedman (2003) noted, this is not based on feelings alone, nor does it take connection as an instrumental tool, but instead allows us to understand from inside the common world created in the relation. The "alchemy of connection" describes these three aspects (see Figure 1).

The bridge refers to the intersection that joins the worlds of the breastfeeding mother (*Thou*) and the LC (*I*) through a shared interpretation of their circumstances. The LC willingly crosses this bridge to support the breastfeeding dyad; the mother also crosses it when seeking help. As Eliopoulos (2017) suggested, clinical skills and judgment, competency, and interpersonal and communication tools that reflect maturity are necessary. Thus, the LC as a clinician brings clinical competencies, clinical judgment, and communication and counseling skills, as well as their presence. The patient/client is a unique personality and a universe of lived experiences and relationships appearing in a context full of social meaning (Kabat-Zinn, 2000), which the connection must help bridge.

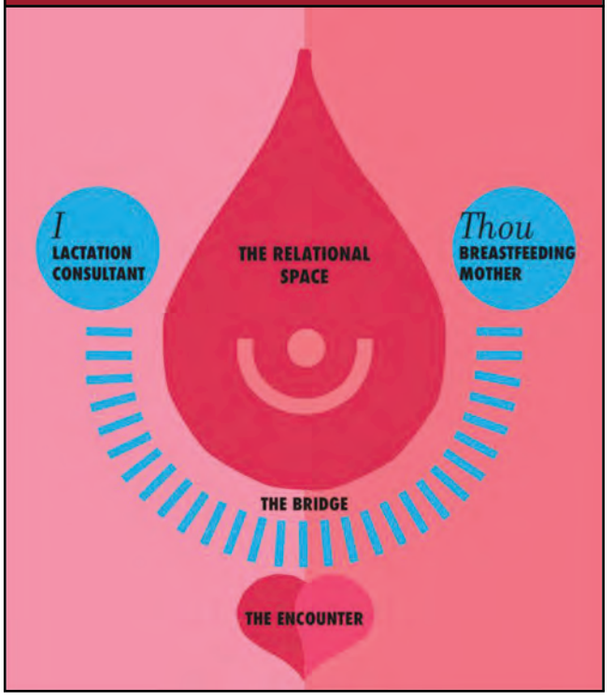
The LC begins by establishing a rapport with the breastfeeding mother, while following a methodology. This includes gathering information (Kurtz, Draper, &

Table 1. Definitions

The bridge	The intersection where the breastfeeding mother with her problems and the LC with their circumstances (clinical competencies and communication skills) meet.
The relational space	The physical space where the therapeutic interaction between the LC and the breastfeeding dyad takes place.
The encounter	A moment in time between the LC and breastfeeding mother, where, in the "holding space," bearing witness can take place and human connection can flourish.

Note. LC = lactation consultant.

Figure 1. The alchemy of connection.



Silverman, 2005) through presentation of symp toms and problems, history, assessment findings (observing a full feed), and investigations. These include, when applicable, visual examination of breasts (or palpation), performing an infant intraoral exam, making appropriate suggestions to improve position and attachment, explaining the findings, and, finally, planning and elaborating in partnership a dyad-centered feeding plan, followed by appropriate follow-up sessions.

In this context, language is the foundation of the bridge and the interaction between the LC and the mother. We know that "when two people feel rapport . . . their very physiology attunes" (Goleman, 2006, p. 28). Rapport is defined as a close and harmonious relationship in which people seek to understand each other's feelings or ideas and work to communicate well. Rapport differs from human connection, which entails choosing to enter into a relation in the specific context of the bridge created with the mother, and the ability to bear witness there of her situation.

The relational space refers to the physical space where the consultation takes place. It might be a busy postnatal hospital ward, a breastfeeding clinic, a breastfeeding drop-in café, a mother-to-mother support group, or the home of the client. Ideally, this is an "oxytocin-boosting environment," or what Kathleen Kendall-Tackett has coined "an oxytocic environment"—a place where the mother feels safe and unobserved so her oxytocin levels remain high (Kendall-Tackett, 2019). This setting establishes the foundation for the encounter.

The encounter refers to a space in time. Buber described this as the *meeting of human essence to human essence*. The LC is able to convey their full presence and listen with an open mind and heart, and chooses to enter into a relation of caring and serving. This encounter in turn helps to develop and enhance the bridge, contributing to the circular character of this hermeneutics of care.

Osler's (1922) dictum, "Listen to your patient, he is telling you the diagnosis," is a cornerstone of good medical interviewing and applicable to lactation care. Connection fosters that sense of care and a shared understanding, a ground where seeds of empathy can grow into a relation of mutual trust or *philia* (in Greek). Crucially, this allows for a better interpretation of the evidence and the adequacy of therapeutic approaches, while the dialogue upon which it feeds contributes to empower the mother to take an active role.

Applications for Practice

Healing and care must go hand in hand in the LC–breastfeeding mother relation. "The relationship with providers tends to be a key factor in the oxytocic environment" (Kendall-Tackett, 2019). In addition, LCs strive to provide an optimal oxytocin-boosting environment, where the breastfeeding mother is comfortable, feels safe and unobserved, and is not rushed. Within the constraints of space, there are always minor yet powerful adjustments that can be made when the environment needs an extra "oxytocin boost."

An adequate relational space also makes the mother feel safe to share personal, sensitive information. Is there enough privacy for her to breastfeed comfortably? "We know that the setting itself can facilitate or hinder communication" (Lloyd, Bor, & Noble, 2019). For most breastfeeding mothers (particularly first-time), the sense of privacy is paramount. Feeling exposed can hinder how the breastfeeding dance will unfold in the first few hours, particularly under the influence of the shy hormone: oxytocin (Odent, 2012).

Background noise in a busy hospital postpartum ward will be common, as well as frequent interruptions. Bright light can make a mother feel exposed, or dimmed light

can help a mother feel unobserved. Particularly when working with babies that do not latch and mothers who are therefore under a lot of stress, dimming the lights to reduce neo-cortex stimulation can be particularly useful as it will make the environment more "oxytocin-boosting." In appropriate circumstances, using humor or laughter can have a similar effect.

Being at the same physical level as the mother (Rahman & Tasmin, 2007), or even, when appropriate, being below, can serve as a nonverbal statement of willingness to encounter the mother´s problems and foster a partnership between the LC and the breastfeeding mother. Maintaining eye contact and face-to-face interaction instead of writing notes is also good practice. Implicitly the LC is saying, "I see you. *You are not just a file*. I care about you and I am with you."

Communication and connection often meet. To deliver truly dyad-centered, compassionate care we need to start with the basics. In many busy settings, where time is scarce, LCs sometimes refer to "mother" and "baby" (see Figure 2). "Introductions are about making a human connection between one human being who is suffering or vulnerable and another human being who wishes to help" (Granger, 2019). Pronouncing the names of both the mother and the baby correctly, or at least making a genuine effort, creates an essential foundation for the encounter.

The encounter starts when we are holding space and bearing witness to the truth of that mother. This could mean giving space to the mother to debrief her birth story, to help her untangle her labor puzzle emotionally and in her head. Processing a difficult labor through the act of being heard can help ownership and have tremendous implications for the mother, her self-efficacy, and her breastfeeding outcomes (Kendall-Tackett, 1994; Kendall-Tackett, Cong, & Hale, 2015).

Through the bridge to the encounter, the LC learns to pick up not just the thread of the chief complaint, but also subtler cues that can lead to further emotional and psychological clues (expressed through body language or micro facial expressions). In medicine, but also in the lactation field, "doctors [in this case LCs] need to spot the subtle relational signs, know when *and* how to elicit the relevant information, and care enough to want to do it, time and time again" (Chiavaroli, Huang, & Monrouxe, 2019, p. 233).

When connection has been established, intuition is more likely to sprout and the LC is more likely to pick on nonverbal and body language cues, all of which provide extra clues for those more complex cases. Intuition has an important role in lactation care: "Evidence-informed practice values clinicians' intuition and clinical reasoning skills that come from day-to-day experience of working with a clinical specialty with patients" (Spencer & Watkins, 2019).

If the LC has the courage and humility during the encounter to stay fully present for that mother and her circumstances, connection has been primed. "The doctor [LC in this context] must be able to be touched by the patient's life as well as his or her illness" (Chiavaroli et al., 2019, p. 233).

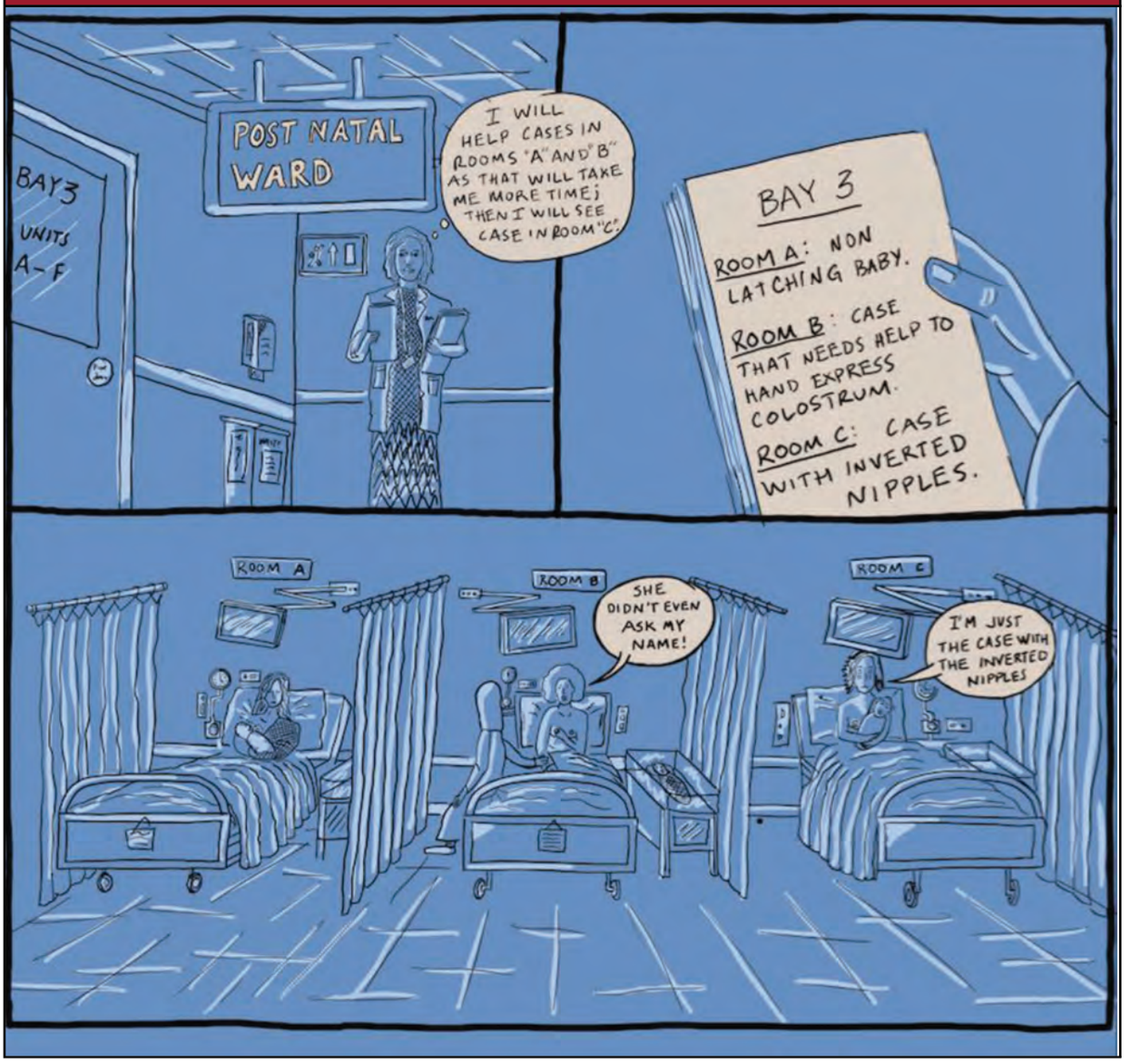
When the LC is touched by the breastfeeding mother's story, then empathy, attention, and genuineness to the truth of someone else's experience can unfold. Moreover, the connection creates an environment of mutual trust, or *philia*, to emerge. This mutual trust can engage the mother, but also her circumstances and how she interprets them (Bruni, 2012), and thus opens up the ground for communities to emerge around the provision of lactation care.

If LCs follow a protocol as a prepared robotic script, or "if nonverbal signals offered [by the LC)] do not match the words being said" (Benbenishty & Hannink, 2015), mothers might detect this and it could hinder connection. A genuine understanding of the context and circumstances of what is said and reflected enhances human connection.

Lack of connection may include ineffective communication and counseling skills—leaving patients feeling anxious, uncertain, and dissatisfied (Hagerty, Butow, Ellis, Dimitry, & Tattersall, 2005). This has been linked to a lack of compliance with recommended treatment regimens (Turnberg, 1997), and those breastfeeding mothers on some occasions turn then to other healthcare professionals (HCPs) or to other LCs.

But poor communication and counseling skills might not be the culprit. Even when using well-polished skills and following the appropriate management protocols, LCs can sometimes feel and acknowledge a sense of disconnection, which can translate as an inability to adequately convey a sense of care (Lussier & Richard, 2005; Moore, Vargas, Nunez, & Macchiavello, 2011). Studies have demonstrated patient discontent even when many doctors (LCs in this context) considered the communication adequate or even excellent (Tongue, Epps, &

Figure 2. Lack of human connection.



Forese, 2005). If that is the case, it is worth asking the LC who is following all clinical protocols and is nevertheless not relating physically, emotionally, and mentally to the breastfeeding mother, how to better engage in such a relation.

Mindfulness, described by Kabat-Zinn (2003), is "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally." As Falkenberg (2017) has shown, mindfulness techniques allow practitioners to observe themselves more attentively in the present moment, as well as patients and their problems (Beach et al., 2013), while avoiding being caught in previous assumptions. More comprehensively, however, connection allows the LC to understand the cause and context of those problems from within the world of the mother, and better respond to them, improving diagnosis while helping the mother realize that she is worthy of being held and supported.

In cases of chronic problems, or when there are no solutions, when a mother does not achieve her

breastfeeding goals or among mothers who have had traumatic births or feel let down by the medical system or other HCPs, human connection has the potential to enhance healing. As the truism states: "People don't care how much you know until they know how much you care." In a wider human context it helps to relieve stress, as the mother knows she is not alone and feels she has someone to turn to.

When unable to attain her breastfeeding goals, a mother's perceptions could be: "I am not good enough. I failed my baby. I am a failure." If a connection has been fostered, she will be more likely to share her feelings of inadequacy, vulnerability, and sadness. By cultivating a connection through the professional relationship, a mother can safely explore those feelings and come to terms with her circumstances, grieve what she could not achieve, and potentially set up a positive healing transformation for subsequent breastfeeding experiences.

Follow-up sessions, continuity of care, and staying in touch with clients also foster connection. Sometimes with vulnerable mothers, LCs might go the extra mile by staying in touch, opening alternative channels of communication, or being available at weekends or when not in "working mode."

Conclusion

The "alchemy of connection" articulates a hermeneutics of care based on Buber's world of the *I–Thou*, which includes three connectors linked in a circular way: the bridge, the relational space, and the encounter. All three seed a climate of trust, empathy, and acceptance that enhances healing, care, and serving. The quality of the LC–breastfeeding mother relation is as important as competent clinical and communications skills, even if separate and complementary to them, and particularly in cases where the complaint is chronic or has no resolution of symptoms. Every encounter with a breastfeeding mother seeking help should aim to set the ground for an emerging human connection.

In sum, connection is a central foundation for effective diagnosis, treatment, and healing to occur to improve breastfeeding support and lactation care.

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